GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH PROFESSIONAL LICENSING ADMINSTRATION

SUPPLEMENTAL INFORMATION FORM

(PLEASE PRINT IN INK OR TYPE)

This form should be completed by:
Physical Therapist

NAME _____ DATE _____
Last, First, MI

ADDRESS_____
Street, City, State, Zip Code

TYPE OF LICENSE

____ PHYSICAL THERAPIST

____ PHYSICAL THERAPY ASSISTANT

1. Are you addicted to drugs, chronic or persistent inebriety, afflicted with contagious disease or physical or mental disability? ____ Yes ____ No If answer yes, attach explanation.

2. Have you ever taken the NPTE or AOTA examination? ____ Yes ____ No If "Yes", what state? _____

   Examination Date_____ Were your scores accepted as passing by that State? ____ Yes ____ No

3. Are you certified by AOTA? ____ Yes ____ No Certification Number_____

4. Character Reference List. List the names and addresses of three responsible persons (other than relatives, instructors or employers) who have known you for at least one year and can attest to your character.

   Name Address (including zip code) Title & Position

   1. _____
   2. _____
   3. _____

EXPERIENCE:

Name of Employer Address (city/state) Position From – To (mm/yy)

1. _____

2. _____

3. _____

If your practice has been limited to a specialty, state which one: _____

From_____ To_____